



## New and Emerging Technology - Coverage Status

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| <b>LOB(s):</b><br><input checked="" type="checkbox"/> Commercial<br><br><input checked="" type="checkbox"/> Medicare<br><br><input checked="" type="checkbox"/> Medicaid | <b>State(s):</b><br><input checked="" type="checkbox"/> Idaho <input checked="" type="checkbox"/> Montana <input checked="" type="checkbox"/> Oregon <input checked="" type="checkbox"/> Washington <input type="checkbox"/> Other:<br><br><input checked="" type="checkbox"/> Oregon <input type="checkbox"/> Washington |
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### Enterprise Policy

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*PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.*

*Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.*

### Background

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New and emerging medical and behavioral healthcare procedures, pharmaceuticals, and devices (collectively "technologies") are often prescribed by physicians and/or marketed to the public before FDA or other government agency approval, or research is available in peer-reviewed literature documenting efficacy, safety, and long-term positive outcomes.

New and emerging technologies are reviewed by the New Technologies and Operational Criteria (NTOC) Committee which is chaired by a PacificSource Medical Director. The PacificSource Behavioral Health Medical Director or behavioral healthcare professional designee is involved in the decision-making process for behavioral healthcare services. Pharmaceuticals are reviewed by the PacificSource Pharmacy and Therapeutics (P&T) committee.

The NTOC Committee bases its recommendation of coverage on review and evaluation of the following resources:

- Available peer-reviewed and evidenced-based literature
- Survey of standards of care and coverage
- Consultation with specialists and expert professionals
- PacificSource group and individual contracts
- Medicare and Medicaid requirements

This “New and Emerging Technologies – Coverage Status” policy outlines the evaluation process of new and emerging technology as well as coverage status of items considered experimental, investigational, or unproven.

## Procedure

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### Commercial

#### **Evaluation Process**

The NTOC Committee reviews and evaluates new technology and new application of existing technology of medical and behavioral healthcare procedures and devices. NTOC Committee members represent key departments and stakeholders who have operational insight or responsibility for applying the criteria developed by the Committee. A PacificSource Medical Director chairs the NTOC Committee and ensures the Behavioral Health Medical Director or behavioral healthcare professional designee is involved in the decision-making process for behavioral healthcare services.

Agenda items for the NTOC Committee to review for coverage status are collected from multiple sources, which include, but are not limited to:

- New CPT or HCPCS codes
- New FDA approvals
- Provider inquiries
- Reports of new technology acquired by a community provider or anticipated to have widespread acceptance
- Utilization reviews and trends
- Vendor requests – vendor requests for reassessment of coverage position are limited to an annual review unless there is a change in FDA status or Hayes, Inc. rating

To inform its decision-making, the NTOC Committee reviews peer-reviewed and evidence-based information, which indicates if the technology is in general use or a community standard, is under continued scientific review (testing/research), is shown to have a demonstrable benefit, or is shown to be safe and efficacious). The reviews may consist of the following:

- Technology assessment consisting of:
  - Information from appropriate government regulatory bodies such as Food and Drug Administration (FDA) and Centers for Medicare & Medicaid Services (CMS)
  - Assessment of peer-reviewed literature and their conclusions concerning:
    - Effect of the technology on health outcomes, with emphasis on random controlled clinical trial outcomes
    - Evidence comparing new technology to established alternatives
    - Results attained outside of investigational settings, with emphasis on studies that were not underwritten by the manufacturer or other sponsor with financial interest in the service or technology
  - Report on long term studies indicating improved health outcomes and clinical trials now recruiting or in process

- Information available from evidence-based resources may vary depending on treatment procedure or device. The evidenced-based resources, which relies on the judgment of experts, include the following resources, with additional resources reviewed as necessary based on the technology being reviewed:
  - Agency for Healthcare Research and Quality (AHRQ)
  - Carelon Medical Benefits Management Clinical Guidelines, formerly AIM (AIM Specialty Health) Clinical Guidelines
  - Alliance of Community Health Plans (ACHP)
  - American College of Radiology® (ACR)
  - American Hospital Formulary Service Drug Information (AHFS® DI™)
  - Bree Collaborative – Foundation for Health Care Quality
  - Centers for Disease Control and Prevention (CDC)
  - Cochrane Collaboration
  - Facts and Comparison®
  - Hayes, Inc., and Hayes Genetic Testing Evaluation Service
  - MCG Health
  - MEDLINE® (component of PubMed®)
  - Micromedex®
  - National Comprehensive Cancer Network® (NCCN)
  - National Institute for Health and Care Excellence (NICE)
  - Oregon Health Evidence Review Commission (HERC)
  - Professional Societies Recommendations and Practice Guidelines
  - UpToDate®
  - U.S. Pharmacopeia Dispensing Information
  - Washington Health Technology Assessment (HTA)
  - Washington Health Technology Clinical Committee (HTCC)
- Survey of similar market carriers and their published coverage position and/or medical policy concerning the service of technology under review
- Utilization and authorization data, as available and applicable

The PacificSource Medical Director may seek input or consult with specialists and professionals who have expertise in the technology when additional information is needed.

The NTOC committee, which includes a Medical Director, makes a determination based on the review of the technology that results in one of two options:

- Covered service, which may include developing specific clinical guidelines criteria
- Deemed experimental, investigational, or unproven (E/I/U) and added to the “New and Emerging Technologies – Coverage Status” policy or as an E/I/U item to an existing policy related to the technology reviewed

- A technology may be indicated for archival (i.e., remains unproven but only requires a review upon request) when the following conditions are met:
  - The scientific evidence does not support clinical efficacy of the technology demonstrated by ONE of the following:
    - There is no general use within the medical community, i.e., the technology does not meet community standards
    - There have not been clinical studies for five or more years, indicating the technology is no longer under scientific review
    - The technology has not been proven to have a demonstratable benefit or been shown to be safe and efficacious
  - Claims utilization indicates PacificSource has not received a request for a period of at least two years
- The unproven technology which has been determined to be archivable, will be moved to an excel sheet (NTOC Agenda Review Schedule) on the [Special Function SharePoint site](#) and noted as archived in the modification history along with associated codes

### **Quality Oversight**

The “New and Emerging Technologies – Coverage Status” policy will be reviewed at least annually.

In addition, an annual report summarizing the NTOC review activity is presented to our Clinical Quality and Utilization Management (CQUM) committee, which consists of external providers and PacificSource Medical Directors, for review.

### **Medicaid**

PacificSource Community Solutions (PCS) follows Guideline Notes 172 and 173 of the OHP Prioritized List of Health Services for guidance on New and Emerging Technology. In the absence of OHP guidance, PCS will follow this policy.

### **Medicare**

PacificSource Medicare follows CMS guidelines and criteria. In the absence of CMS guidelines and criteria, PacificSource Medicare will follow internal policy for determination of coverage and medical necessity.

### **Experimental/Investigational/Unproven Determinations for Coverage Status**

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The new and emerging medical technologies, in the following list have been determined by the NTOC Committee to be experimental, investigational, or unproven (E/I/U) and therefore are not covered. The impact of these technologies on health outcomes has not been established as the current scientific evidence is either not yet sufficient or does not support clinical efficacy.

The NTOC Committee has the authority to add new technologies or revise the determinations listed below based on additional review of current scientific evidence, advice, and recommendations by the NTOC Committee.

**Experimental/Investigational/Unproven Determinations for Coverage Status**

The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

| <b>PROCEDURE</b>   | <b>CPT<br/>HCPCS</b>  | <b>COVERAGE STATUS</b>   |
|--|---|--|
| <b>AcuDetox (Auricle Acupuncture) treatment for prevention, treatment, and harm reduction of substance use.</b>  | No Specific Code<br>97810 97811                             | Not Covered<br>(Experimental/Investigational/Unproven)<br>(Refer to Contract for coverage as well) |
| <b>Allogeneic haemopoietic stem cell transplantation (HSCT) for Crohn's Disease</b>  | No Specific Code<br>36240                                   | Not Covered<br>(Experimental/Investigational/Unproven)   |
| <b>Autologous Serum Eye Drops for treatment of dry eye disease and all other indications.</b>  | No specific code<br>68899                                   | Not Covered<br>(Experimental/Investigational/Unproven)   |
| <b>Auricular Electro-acupuncture (Auricle Electro-acupuncture or Auricle Pulsed Stimulation) (acupuncture points on the ear) for any indication</b>                                | S8930   | Not Covered<br>(Experimental/Investigational/Unproven)   |
| <b>Avance Nerve Graft (human nerve allograft) surgical repair of severed peripheral nerve discontinuities</b>  | No Specific Code<br>64910, 64912,<br>64913                  | Not Covered<br>(Experimental/Investigational/Unproven)   |
| <b>Avise CTD, Avise SLE, Avise MCV, Avise MTX, SLE-key-Rule Out Test – Prognostic tests for Systemic Lupus Erythematosus (SLE) and Connective Tissue diseases</b>                  | No Specific Code<br>84999, 81599,<br>0312U, 83520,<br>0062U | Not Covered<br>(Experimental/Investigational/Unproven)   |
| <b>Bronchial Thermoplasty (BT) (e.g., Alair; Asthmatrix, Inc.) Asthma treatment and other respiratory indication</b>   | 31660, 31661  | Not Covered<br>(Experimental/Investigational/Unproven)   |
| <b>Cala Trio (Cala Health, Inc.) for Treatment of Essential Tremor – (also referred to as transcutaneous afferent patterned stimulation (TAPS)) (e.g.; Cala One and Cala Trio)</b> | K1008, K1019  | Not Covered<br>(Experimental/Investigational/Unproven)   |
| <b>CardioMEMS (CM) HF System (Implantable Pulmonary Artery Pressure sensor device-(PAP)) to</b>  | 33289, C2624  | Not Covered<br>(Experimental/Investigational/Unproven)   |

| <b>PROCEDURE</b>   | <b>CPT<br/>HCPCS</b>                    | <b>COVERAGE STATUS</b>   |
|--|---|--|
| measure heart rate and pulmonary artery (PA) pressure  |   |  |
| <b>Coil embolization of hemorrhoids (Emborrhoid technique) embolization of the hemorrhoidal arteries.</b>  | No Specific Code<br>37241, 37244        | Not Covered<br>(Experimental/Investigational/Unproven)   |
| <b>Continuous Passive Motion (CPM) for Knees and all other joint</b>   | E0935, E0936                            | Not Covered<br>(Experimental/Investigational/Unproven)<br><br>(Legacy Employee Health Plan covers for knees)                               |
| <b>Cryoablation for chronic rhinitis (allergic or nonallergic) (e.g., ClariFix device)</b>   | No Specific Code<br>31243               | Not Covered<br>(Experimental/Investigational/Unproven)   |
| <b>Cranial Electrotherapy Stimulation (CES), also known as cranial electrical stimulation, transcranial electrical stimulation (e.g., Alpha Stimulation Device) for all indications</b>            | No Specific Code<br>E0732, A4596        | Not Covered<br>(Experimental/Investigational/Unproven)   |
| <b>DISC Nucleoplasty (Radiofrequency Coblation) a percutaneous disc decompression (PDD) or radiofrequency coblation -used to treat herniated discs (e.g., ArthroCare System, Per-D Spine Wand)</b> | No Specific Code<br>62287               | Not Covered<br>(Experimental, Investigational/Unproven)  |
| <b>EarliPoint™ Evaluation for Autism Spectrum Disorder</b>   | No specific Code<br>97110 97112         | Not Covered<br>(Experimental/Investigational/Unproven).<br>Disc  |
| <b>Endothelial Function Assessment or testing - Non-invasive (e.g., EndoPAT 2000 test, Peripheral Arterial Tonometry (PAT)) for risk of atherosclerosis and cardiovascular disease</b>             | No Specific Code<br>93998               | Not Covered<br>(Experimental/Investigational/Unproven).  |
| <b>External Iliac Atherectomy procedure (e.g.; Transluminal peripheral atherectomy) for all indications</b>  | 0238T, 0234T,<br>0235T, 0236T,<br>0237T | Not Covered<br>(Experimental/Investigational/Unproven)<br><br>Refer to Category III Current Procedural Terminology (CPT) Codes – “T” Codes |

| PROCEDURE  | CPT<br>HCPCS                     | COVERAGE STATUS   |
|--|----------------------------------|---|
| Extracorporeal shock wave therapy (ESWT),  | 28890                            | Not Covered<br>(Experimental/Investigational/Unproven).   |
| Gastric Emptying Breath Test – (Cairn 13C-Spirulina Gastric Emptying Breath Test (GEBT)) - measurement of the rate of gastric emptying in adults                     | 0106U                            | Not Covered<br>(Experimental/Investigational/Unproven)  |
| Gait Analysis (computerized) (Motion Analysis) for all indications.  | 96000, 96001                     | Not Covered<br>(Experimental/Investigational/Unproven)  |
| Ganglion Impar block for Coccydynia, pelvic pain, and all other indications  | No Specific Code<br>64999        | Not Covered<br>(Experimental/Investigational/Unproven)  |
| Geniculate artery embolization (GAE) (embolization of the knee) – treatment of osteoarthritis related knee pain  | No Specific Code<br>37242        | Not Covered<br>(Experimental/Investigational/Unproven)<br><b>Approved</b> for coverage of knee hemarthrosis |
| HART CADhs® and HART CVE from Prevencio Inc. – for all indications   | 0308U, 0309U                     | Not Covered<br>(Experimental/investigational/unproven)  |
| Implantable shock absorber (e.g., MISHA knee system) for all indications   | No Specific Code<br>L8699        | Not Covered<br>(Experimental;/investigational/Unproven)   |
| Interactive Metronome Training (e.g., attention deficit hyperactivity disorder or any other indication)  | No Specific Code<br>97110, 97112 | Not Covered<br>(Experimental/Investigational/Unproven)  |
| Interferential Current Stimulation Therapy (IFS/ICT) (electrical stimulation) for all indications.   | S8130, S8131                     | Not Covered<br>(Experimental/Investigational/Unproven)  |
| Internal Neurolysis “nerve brushing or combing” – all indications  | No Specific Code<br>64727, 69990 | Not Covered<br>(Experimental/Investigational/Unproven)  |
| Intra-arterial Infusion (Embolization) of imipenem/cilastatin sodium (IPM/CS) refractory interphalangeal (DIP) joint- Osteoarthritis (OA) and all other indications. | No Specific Code<br>37242 20999  | Not Covered<br>(Experimental/Investigational/Unproven)  |

| <b>PROCEDURE</b>   | <b>CPT<br/>HCPCS</b>             | <b>COVERAGE STATUS</b>  |
|--|----------------------------------|---|
| <b>Intravascular Lithotripsy (IVL) – (Shockwave intravascular lithotripsy system (IVL)) Coronary</b>   | C1761                            | Not Covered<br>(Experimental/Investigational/Unproven)  |
| <b>iovera° (Pacira Biosciences Inc.) System (cold injection ) for Knee Osteoarthritis</b>  | No Specific Code<br>64640, 0441T | Not Covered<br>(Experimental/Investigational/Unproven)  |
| <b>IsoPSA blood-based test to assess prostate cancer risk</b>  | 0359U                            | Not Covered<br>(Experimental/Investigational/Unproven)  |
| <b>Jaw Motion Rehab System--(e.g., TheraBite Jaw Motion Rehabilitation System, OraStretch press, and Dynasplint Trismus System) – all indications</b>                                | E1700, E1701,<br>E1702           | Not Covered<br>(Experimental/Investigational/Unproven)  |
| <b>Latera Nasal Implant (Absorbable nasal implants) for all indications</b>  | No Specific Code<br>30999 30468  | Not Covered<br>(Experimental/Investigational/Unproven)  |
| <b>LipiView II Ocular Surface Interferometer images with Dynamic Meibomian Imaging (DMI)</b>   | 92285                            | Not Covered<br>(Experimental/Investigational/Unproven)  |
| <b>Low-frequency ultrasound debridement devices (e.g.; MIST Therapy System; VersaJet System; Qoustic Wound Therapy System) for wound healing and reduction of chronic wound pain</b> | 97610                            | Not Covered<br>(Experimental/Investigational/Unproven)  |
| <b>Lymphaticovenous Anastomosis (LVA) (Lymphovenous bypass or shunt) for lymphedema</b>  | No Specific Code<br>38999, 38308 | Not Covered<br>(Experimental/Investigational/Unproven)  |
| <b>Magnetic Resonance Neurography (MRN), (also known as Magnetic Resonance Neurogram or MR Imaging of the Peripheral Nerves (PNI)) for all indications</b>                           | No Specific Code<br>76498        | Not Covered<br>(Experimental/Investigation/Unproven)<br>(Carelon does not review)   |
| <b>Micro-Current Nerve Therapy (Stimulator) (MET) Devices (e.g., micro-electrical therapy (MET) - decreases pain and facilitate the healing process.</b>                             | No Specific Code<br>E1399        | Not Covered<br>(Experimental/Investigational/Unproven)<br><br>(May available over the counter without a prescription refer to contract language for over the counter) |
| <b>MicroGen DX qPCR &amp; NGS Test (MicroGenDX) (also known as Next Generation testing) - test for</b>   | 0112U                            | Not Covered<br>(Experimental/investigational/unproven)  |



| <b>PROCEDURE</b>   | <b>CPT<br/>HCPCS</b>                              | <b>COVERAGE STATUS</b>                                 |
|--|---|--|
| <b>bacterial/fungi Infection (outpatient only)</b>   |   |  |
| <b>MI-HEART Ceramides Risk Score (measures the risk of adverse cardiovascular events) – for all indications</b>  | 0119U   | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>MiraDry System aka Microwave or electromagnetic energy (microwave thermolysis) for all indications of hyperhidrosis</b>   | No Specific Code<br>17999                         | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>Monarch External Trigeminal Nerve Stimulation (eTNS) System for ADHD in children 7-12 y/o</b>   | K1016, K1017                                      | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>Monochromatic infrared energy (MIRE) (Anodyne Therapy System but not limited to) – (Infrared heating pad system, also known as a monochromatic infrared energy (MIRE) device)</b> | 97026, A4639,<br>E0221                            | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>Nd: YAG laser vitreolysis (YAG Reflex Laser Systems, Ellex) - treatment of vitreous floaters or any other indication</b>  | 67031, 67299                                      | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>Navigated Transcranial Magnetic Stimulation (nTMS) (Nexstim)<br/>Navigated transcranial magnetic stimulation (nTMS) presurgical planning</b>                                      | No Specific Code<br>64999                         | Not covered<br>(Experimental/Investigational/Unproven) |
| <b>Neurofilament light chain (NfL) testing – for all indications</b>   | 0361U   | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>Nociceptive Trigeminal Inhibition Tension Suppression System (NTI-TSS or NTI-tension suppression system) for Headaches and Migraines</b>  | No Specific Code<br>21110, D7880,<br>D8210        | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>Non-Pneumatic Active Dynamic Compression (Dayspring (Koya Medical Inc.)) for Treatment of Lymphedema</b>  | E0678, E0679,<br>E0680, E0681,<br>E0682           |  |
| <b>Occipital Nerve Stimulation (ONS) - intended to prevent migraines</b>   | No Specific Code<br>64553; 61885;<br>61886; 64999 | Not Covered<br>(Experimental/Investigational/Unproven) |

| <b>PROCEDURE</b>   | <b>CPT<br/>HCPCS</b>  | <b>COVERAGE STATUS</b>  |
|--|---|---|
| <b>headaches and all other headaches</b>   |   |   |
| <b>Occipital Nerve Decompression Surgery (ONS) (Also known as Peripheral Occipital nerve decompression surgery or migraine surgery) for Migraine Headaches</b>         | No Specific Code<br>64716, 64722,<br>64732, 64999,<br>64640 | Not Covered<br>(Experimental/Investigational/Unproven).   |
| <b>OSSIOfiber Trimmable Nail System/Compression Screws - Orthopedic Surgeries fixation devices for all indications.</b>  | No Specific Code<br>L8699                                   | Not Covered<br>(Experimental/Investigation/Unproven)<br><br>(May be included in surgical procedure)             |
| <b>Ovarian or Internal Iliac Vein Embolization for Treatment of Pelvic Congestion Syndrome</b>   | No Specific Code<br>37241                                   | Not Covered<br>(Experimental/Investigational/unproven)  |
| <b>Patency Capsule Testing (e.g., PillCam Patency, Agile System/Capsule) for all indications</b>   | No specific code,<br>91299                                  | Not Covered<br>(Experimental/Investigational/Unproven)  |
| <b>Percutaneous Needled Tenotomy (PNT) (US Percutaneous Needle Tenotomy, Percutaneous Fasciotomy) with or without Tenex Treatment System - for all indications</b>     | No Specific Code<br>20999, 27599,<br>17999, 25999           | Not Covered<br>(Experimental/Investigational/Unproven)<br><br>(May be coded depending on the area of treatment) |
| <b>Percutaneous electrical nerve stimulation (PENS)/percutaneous neuromodulation therapy (PNT) all indications (e.g., chronic musculoskeletal or neuropathic pain)</b> | No specific code<br>E1399, 64999                            | Not Covered<br>(Experimental/Investigational/Unproven).   |
| <b>Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)</b>  | 92972   | Not Covered<br>(Experimental/Investigational/Unproven)  |
| <b>PortableConnect/ ROMTech (ROMTech Portable Connect Rehab Adaptive Device) (e.g., postsurgical rehabilitative exercises) for all indications</b>                     | No Specific Code<br>E1399 90091                             | Not Covered<br>(Experimental/Investigational/Unproven)  |
| <b>Pregnancy Ultrasound (Four-dimensional (4D) or (5D) five-</b>   | No Specific Code<br>76499, 76999                            | Not Covered<br>(Experimental/Investigational/Unproven)  |

| <b>PROCEDURE</b>   | <b>CPT<br/>HCPCS</b>   | <b>COVERAGE STATUS</b>                                 |
|--|--|--|
| <b>dimensional imaging for all indications.</b>  |  |  |
| <b>Prescription Digital Therapeutics (PDT) (prescription-only software to manage medical disorders or diseases)</b>  | No Specific Code<br>99199, E1399,<br>T1505, A9291,<br>A9999, A9292 | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>Pulsed electromagnetic stimulation (PEMF)/Target Pulsed Electromagnetic field therapy (tPEMF)/Electrical Magnetic Therapy (e.g., OthroCor Active Knee System, SoftPulse Device) for all indications</b> | E0761  | Not Covered<br>(Experimental/Investigation/Unproven)   |
| <b>Radiofrequency Intradiscal Biacuplasty (IBD) (e.g., Bialys TransDiscal System or Biacuplasty) (referred to as (TIPs)) for all indications</b>   | No Specific Code<br>22899  | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>Radiofrequency Nasal Valve w/VivAer Device – Treatment of nasal airway obstruction</b>  | 30469  | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>Reverse Axillary Lymphatic Mapping (ARM Technique where dye is injected - all indications</b>   | No Specific Code<br>38999, C9756,<br>92240                         | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>RhinAer Procedure (Aerin Medical) (posterior nasal nerve ablation using radiofrequency) for Treatment of Chronic Rhinitis</b>   | No Specific Code<br>31242 30999                                    | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>ShuntCheck® to detect fluid flow in CSF shunt</b>   | 62252  | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>SofPulse pulsed electromagnetic therapy (tPEMF) (Shortwave Diathermy device) for all indications</b>  | No Specific Code<br>E0761  | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>Sphenopalatine Ganglion Nerve Block (with or without use of the Spheno-Cath device) for any indication including, but may not be limited to, headaches or trigeminal neuralgia.</b>                     | No Specific Code<br>64505  | Not Covered<br>(Experimental/Investigational/Unproven) |

| <b>PROCEDURE</b>  | <b>CPT<br/>HCPCS</b>                    | <b>COVERAGE STATUS</b>                                 |
|---|---|--|
| <b>Subacromial Balloon Spacer Implantation (InSpace) Rotator cuff repair or any other indication</b>  | No Specific Code<br>29999, C9781        | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>Supraorbital Nerve Block Injection w/Ultrasound (SON) - for all indications (e.g., Migraine Headaches suboccipital neuralgia)</b>                      | No Specific Code<br>64400 64999         | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>Surface electromyography (SEMG) (Myovision; Insight Discovery also known as surface scanning EMG) to assess muscle function</b>                        | No Specific Code<br>S3900, 96002, 96004 | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>Thermal Capsular Shrinkage Therapy (e.g.; Thermal capsulorrhaphy or Electrothermal Shrinkage) for all orthopedic indications</b>                       | No Specific Code<br>29999, S2300, 25320 | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>TissueCypher Barrett's Esophagus Assay (e.g., diagnosis and management of Barrett's esophagus and other esophageal disorders)</b>                      | 0108U                                   | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>Trabecular Bone Score (TBS) Bone Mineral Density Measurement) to Predict Fracture Risk in Postmenopausal Patients</b>                                  | 77089, 77090, 77091, 77092              | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>Transcutaneous Vagal Nerve Stimulator (t-VNS) and Vagus Nerve Stimulation (VNS non-implantable) (e.g., depression/Bipolar/psychological disorders)</b> | E0735                                   | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>Ultrasound-guided Percutaneous Barbotage procedure (needling and lavage procedure) -all indication except calcific tendinosis of the shoulder</b>      | No Specific Code<br>27299               | Not Covered<br>(Experimental/Investigational/Unproven) |
| <b>Vagus Nerve Stimulation (Non-implantable, noninvasive tVNS, gammaCore Sapphire Device) for cluster and migraine headaches</b>                          | E0735                                   | Not Covered<br>(Experimental/Investigation/Unproven)   |
| <b>Vascular Lymph Node Transfer (VLNT) also called lymph node</b>   | No Specific Code<br>38999, 38308        | Not Covered<br>(Experimental/Investigational/Unproven) |

| PROCEDURE  | CPT<br>HCPCS              | COVERAGE STATUS  |
|--|---------------------------|--|
| <b>transfer (LNT); Lymphatic By-pass Procedure) for all indications</b>  |                           |  |
| <b>Vertebral axial decompression (e.g., Lordex; VAX-D; DRX, and DRS System), (mechanized spinal distraction therapy or non-surgical traction device) for back pain</b> | S9090                     | Not Covered<br>(Experimental/Investigational/Unproven)   |
| <b>Virtual Reality Cognitive Behavioral Health therapy device</b>  | E1905                     | Not Covered<br>(Experimental/Investigational/Unproven)<br><br>(All “T” code related to Virtual Reality denied per Category III Policy) |
| <b>Whole Body Vibration Platform (Galileo Plate ) for all indications</b>  | No Specific Code<br>E1399 | Not Covered<br>(Experimental/Investigational/Unproven)   |
| <b>Wireless GI Motility Capsule Testing (e.g., SmartPill Mobility Testing System) – for all indications</b>  | 91112                     | Not Covered<br>(Experimental/Investigational/Unproven)   |

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## Related Policies

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Category III Current Procedural Terminology (CPT) Codes

Medical Necessity Reviews

## Appendix

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**Policy Number:**

**Effective:** 1/1/2021

**Next review:** 3/1/2025

**Policy type:** Enterprise

**Author(s):**

**Depts.:** Health Services

**Applicable regulation(s):** NC Social Security Act Section §1862 (a), 42 CFR 411.15(o), NCQA UM 10(A)(B) – Evaluation of New Technology; Guideline Notes 172 and 173 of the OHP Prioritized List of Health Services for guidance on New and Emerging Technology; WAC 284-44-043, WAC 284-46-507, IDS 41-3930, 41-5903, MCA 33-32-103, ARM 37.82.102(c)QA UM 10(A)(B) – Evaluation of New Technology; Guideline Notes 172 and 173 of the OHP Prioritized List of Health Services for guidance on New and Emerging Technology; WAC 284-44-043, WAC 284-46-507, IDS 41-3930, 41-5903, MCA 33-32-1003, ARM 37.82.102(c)

**Commercial OPs:** 5/2024

**Government OPs:** 4/2024